"I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People

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For people who are transgender, transsexual, or transitioned (trans), access to primary, emergency, and transition-related health care is often problematic. Results from Phase I of the Trans PULSE Project, a community-based research project in Ontario, Canada, are presented. Based on qualitative data from focus groups with 85 trans community members, a theoretical framework describing how erasure functions to impact experiences interacting with the health care system was developed. Two key sites of erasure were identified: informational erasure and institutional erasure. How these processes work in a mutually reinforcing manner to erase trans individuals and communities and produce a system in which a trans patient or client is seen as an anomaly is shown. Thus, the impetus often falls on trans individuals to attempt to remedy systematic deficiencies. The concept of cisnormativity is introduced to aid in explaining the pervasiveness of trans erasure. Strategies for change are identified.

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Trans is an umbrella term that encompasses a diverse group of people whose gender identity or expression diverts from prevailing societal expectations. Trans includes transsexual, transitioned, transgender,

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Editors' note: *This article contains graphic language and content. JANAC's editorial staff is dedicated to preserving the integrity of the work of all of our authors. In qualitative research, this includes input from participants who are willing to share their experiences with the researcher and—eventually—with the reader. In this article, we have honored those individuals by leaving their words intact.*

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and genderqueer people, as well as some two-spirit people. The corresponding terms *cissexual* and *cisgender* typically describe nontrans people (see Table 1).

Trans people represent one of the most marginalized groups in our society. Numerous needs assessments and research studies published to date have consistently indicated the numerous and interlocking challenges that trans people experience in their day-to-day lives (Kenagy, 2005; Namaste, 2000; Sperber, Landers, & Lawrence, 2005; Taylor, 2006). Despite consistency of results, little attention has been focused on understanding how and why trans people come to experience marginalization in such pervasive ways.

Background and Significance

Health is a holistic state. Mental, physical, emotional, and social health are all integral to and interact toward the total experience of health (World Health Organization, 1948). A social determinants of health framework recognizes that the conditions for health are shaped by the social and political milieu in which one lives (Raphael, 2004). As an extension of this approach, risk for HIV can be viewed as a synthesis of both proximal and distal risk factors, and social determinants of health can increase vulnerability to HIV at the community level (Sumartojo, 2000). HIV has been shown to disproportionately affect marginalized groups (Atrill, Kinniburgh, & Power, 2001), and in Canada, a strong case has been made to understand HIV within social contexts. The Canadian Public Health Association (2005) noted that "poverty, homelessness, stigma, addiction, violence, untreated mental health problems, lack of employment opportunities, powerlessness, lack of choice, lack of legal status, and lack of social support create an environment in which HIV and other illnesses flourish and spread" (p. 26).

Viewed through a social determinants of health lens, the existing body of literature clearly indicates that trans people frequently face a multiplicity of challenges to their health and well-being. These include challenges to accessing relevant health care services (Dewey, 2008; Sperber et al., 2005; Xavier, Hannold, Bradford, & Simmons, 2007). Additionally, access to social services including homeless shelters, addictions services, and sexual assault services is often fraught with challenges (Cope & Darke, 1999; Nemoto, Operario, Keatley, Nguyen, & Sugano, 2005; Sperber et al., 2005). Accessibility and relevance issues have also been documented in relation to harm reduction and HIV prevention work (Bockting, Robinson, & Rosser, 1998; Cope & Darke, 1999). In their day-to-day lives, trans people often experience direct harassment and discrimination in institutional and broader social contexts (Feinberg, 2001; Hill, 2003).

Trans people frequently encounter barriers to maintaining a stable income and quality housing (Gapka & Raj, 2003; Namaste, 2000; Xavier et al., 2007). It has also been shown that they experience disproportionately high rates of violence, harassment, and discrimination in workplaces, schools, and child welfare systems (Lombardi, Wilchins, Priesing, & Malouf, 2001; Sperber et al., 2005). Moreover, there are few jurisdictions where basic human rights protections for trans people exist and even fewer where they are enforced (Currah & Minter, 2000; Minter & Daley, 2003). Particular subgroups of trans

Table 1. Transgender Terminology

Term	Definition
Transsexual	"Those who live as members of the sex other than the one they were assigned to at birth." (Serano, 2007, p. 25)
Transgender	An umbrella term used since the 1990s "to describe those who defy societal expectations and assumptions regarding femaleness and maleness; this includes people who are transsexual…, intersex (those who are born with a reproductive or sexual anatomy that does not fit the typical definitions of female or male), and genderqueer (those who identify outside of the male/female binary), as well as those whose gender expression differs from their anatomical or perceived sex…." (Serano, 2007, p. 25)
Cissexual	"People who are not transsexual and who have only ever experienced their subconscious and physical sexes as being aligned." (Serano, 2007, p. 12)
Cisgender	"People who are not transgender." (Serano, 2007, p. 33)

communities including Aboriginal trans people, newcomers, and youth can experience compounded challenges because of intersections with other experiences of marginalization (Clements, Katz, & Marx, 1999; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Reback & Lombardi, 2001).

Research has also highlighted the impact of marginalization on the health of trans people (Bockting et al., 1998; Sugano, Nemoto, & Operario, 2006). In particular, high prevalence rates of HIV infection have been shown to be common in trans communities. A recent metaanalysis estimated a prevalence rate of 27.7% for trans women in North America (Herbst et al., 2008), and HIV risk and low self-esteem have been shown to be related (Bockting et al., 1998; Sugano et al., 2006). Moreover, marginalization can increase the risk of suicide; in one of the largest studies of trans people to date ($N = 350$), suicidal ideation among trans people was estimated to be 65% (Xavier et al., 2007).

Despite consistent documentation that trans people are routinely exposed to direct and indirect experiences of discrimination and harassment and are often unable to access health and social services, analyses that have attempted to explain how such marginalization gets produced have been notably absent. When explanations for the exclusion that trans people experience have been provided, the tendency has been to attribute the marginalization as a consequence of transphobia (i.e., fear or hatred of transgenderism or transsexuality). Whereas transphobia may be a useful concept in understanding the motivations underlying the actions of individuals, its use as an explanation has obscured the more systematic nature of trans marginalization by isolating the particular problem to acts rather than embedding the problem in broader cultural and political contexts. Thus, the pervasiveness of transphobia to explain trans people's experiences of marginalization has obstructed the development of analyses that help us to understand the mechanisms that underlie, sustain, and give rise to the challenges experienced by trans people in their daily lives.

This article provides one of the first schemas for understanding the process through which trans people come to experience marginalization and vulnerability to HIV infection, with a focus specifically on the processes that exclude trans people from accessible and appropriate health services. The concept of erasure, described by Namaste (2000) as "a defining condition of how transsexuality is managed in culture and institutions, a condition that ultimately inscribes transsexuality as impossible" (pp. 4-5), is used as a framework. Drawing on data gathered from a series of focus groups, the often discriminatory actions and assumptions that occur at individual, organizational, and systemic levels are highlighted.

Methods

The Trans PULSE Project

With a population of approximately 13 million, Ontario is Canada's most populous province. Trans PULSE is an Ontario-wide project that aims to broadly understand how social exclusion impacts the health of trans people. The Trans PULSE Investigators Team, with seven trans and three cissexual members, is an active partnership between community members, service providers, and academic researchers who share a desire to undertake community-based research that will help to alleviate the systemic inequities facing trans people in Ontario. Community-based research involves collaborative efforts to equitably involve partners in addressing a community-relevant research question to improve health and eliminate disparities (Community Health Scholars Program, n.d.). Trans PULSE is a mixed-methods study usng both qualitative and quantitative components. Phase I consisted of a set of "community soundings," or focus groups, designed to elicit concerns about a range of health and health care issues among trans people in various Ontario communities. Phase II, which is in process, involves a survey component and uses a respondent-driven sampling method. Phase III will seek qualitative input to provide depth of understanding to key survey results. The present report draws upon Phase I data.

Data Collection

In the summer of 2006, seven community soundings were held in the Ontario cities of Toronto, Ottawa, and Guelph ($N = 85$ trans community

members, 4 "allies"). Promoted through posters and listserv postings as well as through local support groups and community agencies, soundings were led by trans investigators from the research team and run as "trans-only spaces," with the exception of one group held for allies and family members. Groups ranged in size from 3 to 27 participants; each participant was provided a $20 honorarium for participation. Discussions were semistructured and designed to address the following areas to stimulate broad discussion about health: individual health concerns, health care experiences, efforts to maintain personal health, health education and resources, the role of communities, and HIV-related risks and services. The Trans PULSE Investigators Team developed the questions and parameters for the community soundings.

Demographic data were collected via a brief survey before the soundings. The survey was completed by 65 (76.5%) of the trans participants. Discussions were recorded, transcribed, and error-checked. Data were managed using NVivo version 7 qualitative data management software. Informed consent was obtained from all participants before data collection, and study design and data collection procedures were approved by the research ethics board at the University of Western Ontario.

Participants

Trans participants were 85 people age 18 and over who ranged across all educational levels. Of the participants from whom demographic information was collected ($n = 65$), income levels were low, with 32 (49.2%) earning less than $20,000 annually. A total of 10 (29.2%) described themselves as unemployed or underemployed, and an additional 8 (12.3%) reported that they were unable to work. Participants worked in a wide range of occupations. About one third ($n = 23$, 35.4%) were partnered or married, and a smaller number ($n = 10$, 15.4%) had children. Participants were born in a range of countries, and 55 (84.6%) were Canadian citizens. Most ($n = 45$; 69.2%) had lived in Canada their entire lives, and 14 (21.5%) had lived in the country more than 10 years. Self-described gender identities showed a broad diversity of identity including woman, male-to-female, genderqueer, two-spirit, boy, and bigendered. Participants also showed a range of sexual orientations including lesbian, gay, pansexual, bisexual, and heterosexual.

Data Analysis

Analysis of data was undertaken using a grounded theory approach to allow for the natural emergence of pattern and theory (Glaser, 1992). Open thematic coding was completed by two trans community members: one investigator and one graduate student. Numerous principles of community-based research have guided the work of Trans PULSE. Particularly important was the desire to ensure that trans community team members felt ownership of the research processes and outcomes and that attention was paid to capacity-building and demystifying research processes (Minkler, 2005). As part of this process, participatory data analysis sessions were conducted. "Mind maps" representing key themes (Tattersall, Watts, & Vernon, 2007) were prepared by a trans graduate student during a summer internship with the project. Discussions were undertaken about the meanings and key themes that emerged from the data, and the broad theory of erasure outlined in the Results section of this report was conceptualized. Using the constant comparative method outlined by Glaser and Strauss (1967), confirming and disconfirming evidence was sought in the data to support the credibility of theory development. To give priority to the voices and lived experience of trans people, their quotes are included verbatim as supporting data in the results.

Results

Thematic analysis yielded the following key concerns regarding health: income instability, barriers to accessing trans-inclusive health care services, the lack of relevant and accessible information, systemic social service barriers, self-esteem and mental health issues, challenges to finding help, and relationship and sexual health concerns. These concerns were characterized by pervasive and diverse experiences of transphobia. Although community soundings covered a broad range of topics, much of the discussion focused on

experiences within health care systems and included the following difficulties: interacting with physicians, nurses, staff, and mental health providers; finding accurate information; and accessing primary, hospital, mental health, and transition-related care. This article focuses specifically on health care concerns, although the experience of social exclusion and the processes of erasure described also apply broadly in other contexts.

Erasure appeared in two key domains in the analysis: informational systems and institutional policies and practices. Erasure could be passive or active. Passive erasure included a lack of knowledge of trans issues and the assumption that this information was neither important nor relevant. Active erasure could involve a range of responses from visible discomfort to refusal of services to violent responses that aimed to intimidate or harm. Active and passive erasure within these two domains produced systemic barriers to care and served to reinforce the erasure of individual trans people and, by extension, trans communities.

Informational Erasure

Informational erasure encompasses both a lack of knowledge regarding trans people and trans issues and the assumption that such knowledge does not exist even when it may. It is manifest in research studies, curricula, and textbooks and in the information learned by or readily accessible to health care providers and policy makers.

Health research commonly does not allow for identification of trans participants or address questions relevant to trans communities. It often erroneously presumes that all research participants are cissexual, that their partners or family members are cissexual, and that their sex and gender have been consistent over the lifetime. Thus, trans people who have been research participants have been systematically erased, and by extension, trans experience and subjectivity have been similarly rendered invisible. The social exclusion produced has a cumulative impact because trans bodies are not counted or not recognized. Social exclusion is experienced profoundly by individuals. One participant put it frankly, as follows:

> I'm one of the dead ones. Remember [this], just because you're TS [transsexual], you're one of the dead ones. All of this time that I've survived, I'm one of the walking dead because we're not counted; we're not represented anywhere.

The lack of research on trans lives and trans issues has resulted in a dearth of information on health-related topics, including issues related to family practice, mental health, and trans-specific health care, which includes transition-related as well as primary health care concerns. A participant elaborated on this theme.

> I think that one of the things that bothers me personally is the lack of information on long-term worries healthwise. Here I am, I've had SRS [sex reassignment surgery]. How is it all going to work in 40 years? I have no idea. Do I have to worry about breast cancer? Do I have to worry about prostate cancer? There's a few studies, but they are so little that they can't really tell us what the heck is going to happen to us eventually. I think we need that kind of data. I'd like to ask my doctor "Well, what should I worry about?" and not hear "Well, I have no frickin' idea."

For mental health care professionals, information on trans people exists primarily with regard to gender identity disorder as a *Diagnostic and Statistical Manual of Mental Disorders-* (American Psychiatric Association, 2000) classified mental disorder. The lack of information on how gender identity relates or does not relate to mental health allows provider assumptions to manifest in ways that erect barriers to care. Although research results have shown that transsexual people are no more likely to suffer from psychopathology than cissexual people (Haraldsen & Dahl, 2000), providers may perceive unrelated mental health issues to stem from a person's gender identity. One participant explained as follows:

> Another thing is not just the mental in regards to our trans experience, but also sometimes we have other mental illnesses. So if we're trying to get help, some doctors may blame it on the trans aspect or reality, when in fact there's an actual illness.

Another participant explained that conversely, providers might assume that a person's gender identity stems from mental health issues and is not legitimate in the comment that, "There are trans issues, and there are mental health issues. But also if there's a mental health [issue], sometimes the trans issues are discarded. 'Oh, you're not really trans, you're dealing with such and such an issue.'"

This double bind presents a situation in which it can become difficult for transgender persons to obtain appropriate care for mental health issues. Providers rarely receive information presented in a way that allows them to see a person's mental health issues as separate from trans status and tend to discount one or the other or link what may be unrelated issues. This blurring or blinding of issues may result in inadequate or inappropriate care.

Research that has included trans people may be generated through processes that are stigmatizing and alienating to participants, and much of it has been generated in university or clinical settings without the input of communities being studied. Three study participants explained in the following exchange:

> Participant 1: I'm just tired of feeling like the fucking Elephant Man. Either they ignore you or they treat you like a bloody…
> Participant 2: …Research animal.
> Participant 3: …Guinea pig.

When information has been produced, it is often not incorporated into textbooks, educational curricula, health care protocols, or other summary documents, or it is incorporated in a way that conflates gender identity with sexual orientation. This erasure reflects the priorities, biases, and oversights of writers and publishers who function in a cisnormative system, one in which people are assumed to be cissexual. One participant elaborated as follows:

> I've taken two [courses] so far…. [In] the first-year class, transsexual…was not even half a paragraph in the 500 giant-page book, and it wasn't even its own section. It came under the section, and this is seriously the title, "Homosexuality." …In my second-year course, which is much more in-depth, they didn't even mention transsexuality or gender deviance at all.

Information on community-sensitive policies and practices in health care that addresses the needs of trans people is often geared toward serving the lesbian, gay, bisexual, or transgender (LGBT) client or patient. Such materials often omit specific issues of trans clients or erroneously assume that issues around gender identity are similar to issues around sexual orientation. A participant clarified; "Trans and gay is [sic] not necessarily the same thing. Just because someone knows a lot about gay stuff doesn't mean they know a lot about trans stuff or they are even accepting."

This pervasive absence of information, along with stunted knowledge production and dissemination, greatly affect the ability of trans people to access health care services. It manifests in an unwillingness on the part of providers to transcend obstacles to gain access to information or to use the information that has been made available. A participant explained as follows:

> I've had more issues with lack of knowledge, having to [educate] my GP [general practitioner] and my gyno [gynecologist]…. Not only do they not have the knowledge, but they have no interest to learn. You can give them information, you can offer them resources, but they cannot be bothered. So they would much rather pass you off and get you out of the office—"pass the tranny."

The movement of trans clients from one health care provider to another is another instance of erasure because it is impossible to know if these clients actually tried to access services at another location or if they simply stopped visiting health care providers. "Passing off" trans clients also results in the underutilization of research data and resources. This may create an impression of population scarcity and contribute to a perception of limited need.

The theme of having to educate one's own providers was shared by many participants. Providers had not received education on trans health issues and working with trans patients or clients. Thus, when a trans person walked through the door, providers were not prepared. One participant suggested the need for increased awareness.

> How about raising awareness? So that when you walk into the doctor's office for the first time,

> you can say, "Hi, I am trans," and they don't get this glazed, blank look that goes "Oh yeah, I've never seen one of you before."

Health care providers' lack of preparation for working with trans patients or clients stems in part from inaccurate current estimates of the size of trans populations. Given oft-cited estimates from the Netherlands of 1 in 30,400 born females and 1 in 11,900 born males being transsexual (Bakker, Van Kesteren, Gooren, & Bezemer, 1993), there would be approximately 615 such people in Ontario, including children and infants. Although actual numbers are unknown, one publically funded community health centre in Toronto, which is mandated to provide primary health care services to LGBT communities, currently has more trans clients than should exist in the entire province, given these estimates. Moreover, this agency serves a local catchment area, and many trans people in Toronto (and all trans people in the remainder of the province) do not receive health care there. Several participants identified a concern regarding the underestimation of the size of the trans community and its impact on resources and knowledge production. A participant noted the following:

> In my opinion, until we blow that myth out of the water, we're only going to get funding that's based on a 1 in 30,000 of the population. If we are, as some would believe, 1 in 1,500 to 2,000, then we should get 15 times the attention and funding.

The perception that trans people are rare reinforces an erasure of trans communities and the continuing treatment of trans people as isolated cases. Erasure of trans communities extends from the cumulative invisibility of trans people through the processes discussed earlier as well as through other mechanisms such as infrequent or pathologizing media portrayals (Serano, 2007). There is also a tendency to see trans people from a clinical rather than community perspective, and this bias results in an inability to recognize someone as trans if they do not fit a particular stereotype. As a result, the cumulative invisibility of trans people has meant that the overall prevalence of trans people has continued to be grossly underestimated. These widely cited population estimates come from assessments of surgery-seeking transsexual people, who represent only a portion of the broader trans community. A participant elaborated as follows:

> Health care professionals need to have a sensitivity…that there are so many different kinds of trans people, and to have an assumption about a person because they identify as trans when they come through your door, you can't have any assumption, because there is such a huge range about what it means to be trans.

Assumptions about what a trans person looks like, what their issues are, or what they need result from a lack of research characterizing the diversity within trans communities. Trans participants in the authors' community soundings had varied gender identities, came from a wide variety of ethnic communities, were born in numerous countries, and worked across the full range of professions. Research into the specific needs of particular groups (e.g., trans men, trans women, genderqueer or bigendered people, two-spirit trans people, trans immigrants, trans sex workers, trans people living "stealth" or living in isolated communities, trans youth, trans seniors) is needed to understand the full scope of health-related needs within trans communities.

Institutional Erasure

Institutional erasure occurs through a lack of policies that accommodate trans identities or trans bodies, including the lack of knowledge that such policies are even necessary. This form of erasure is actualized in several ways. The possibility of trans identities can be excluded from the outset in bureaucratic applications such as texts and forms. This is most often apparent on referral forms, administrative intake forms, prescriptions, and other documents. One participant described difficulties with how prescriptions were handled.

> Right away, the way [my doctor] named my folder, the way he's done all my prescriptions, he's taken my new chosen name, and my birth name is included in the middle, bracketed. He's written up all my prescriptions that way, but when I take it to the pharmacist—and I've

> taken it to two different pharmacies—regardless of what's written on that prescription, they write down my birth name only.

Other participants described difficulties based on the sex designation on their provincial insurance card. One participant explained as follows:

> Even just not seeing the doctor [is affecting my health]; like, I am not going…telling them I am trans and have to drop my drawers, like forget it. And now my health card reads *male*, and I had to get an ultrasound, and it's the second time I had problems going for an ultrasound. The first time my health card read *female*, and the second time it read *male*, both times I sort of had a problem…. I couldn't get a consult with a gynecologist anywhere, with any of the doctors—my nurse practitioner called every single one. So, like, that is scary.

Sex designations on health-related documents can affect a patient's experience while receiving care. Staff may assume it is an error and try to get it corrected, or alternately, it may "out" a patient as trans. Sex designations play another critical role in care because billing systems are often set up with an assumption of concordance between listed sex and body parts and allow billing for sex-specific procedures only to individuals of that designated sex. Thus, it becomes problematic to bill for such things as a hysterectomy for a male patient or prostate-related treatments for a female patient. In these examples, erasure is embedded, both in the omission of a designation for trans individuals and in the attempt to reinscribe or "correct" a designation for access to service.

From an institutional standpoint, trans identities are erased through an absence of safe, trans-inclusive spaces. In sex-segregated systems such as hospital wards or women's clinics, trans people are often forced to choose between accessing services according to their birth sex or foregoing services entirely. Two participants described their experiences as follows:

> Participant 1: I felt like shit. Here I am in this women's ward, on this women's floor, the only guy, and it's pretty awkward…it's so uncomfortable. I felt like shit.
>
> Participant 2: I went [to a hospital] once, but once they found out I was transsexual, oh my god, everything changed. They made me wait; they put me in a different bed….

This form of institutional erasure is then applied through actual practices that exclude or ignore the possibility of providing service to trans clients. Broadly, trans people seeking health care are often faced with the acute realization that many providers are not familiar with or willing to accept the possibility of trans identities, which impacts both the availability and quality of care. Embedded in this particular configuration of institutional erasure is a politics of recognition regarding being in the appropriate place or possessing the correct anatomy to be provided service. A participant recalled the following:

> I got told by one of those three doctors that I should probably seek health care elsewhere…because, for some reason, he did not know [that I was trans] in advance, because that wasn't what I was seeing him for, and when he found out, he pretty much said word for word, "Please go someplace else," so that he wouldn't have to deal with it. Now, thankfully, this guy's leaving town in about a week, so I wouldn't care but…it bothers me immensely that we're still treated that way by people who should know better.

Many trans people must travel to find a welcoming—or at least tolerant—health care environment and feel grateful for receiving adequate care. A participant explained as follows:

> So it's really a privilege if you can get in with any doctor that has at least heard of the word *transsexual* before, let alone is capable of providing…any insight into any particular issue that you're dealing with, or that you feel comfortable working with that won't be put off by your presence there.

All of these instances of institutional erasure are interwoven, with texts and forms, protocols and policies, and institutional infrastructure set up in ways that assume cissexuality and are thus often inappropriate for trans identities, trans bodies, and trans lives. The erasure of trans people in institutional contexts functions with information erasure to form a mutually reinforcing system as illustrated in Figure 1. The lack of information, along with the failure to synthesize

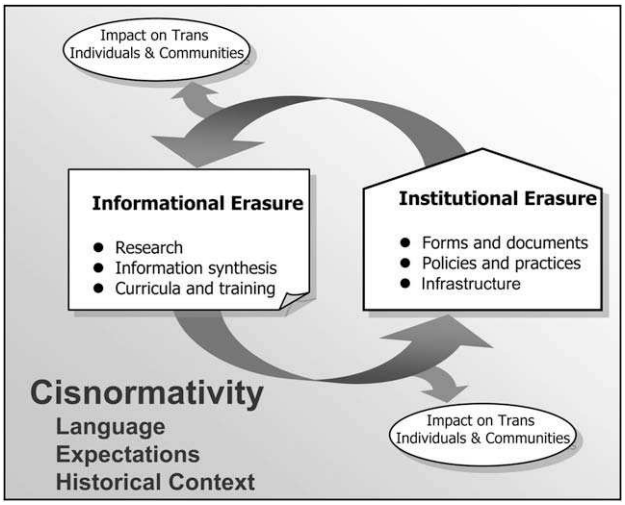

Figure 1. The impact of informational and institutional erasure of trans people within cisnormative systems.

existing information into curricula and texts, contributes to the impression of research scarcity and, by extension, minimizes the importance of trans-related research. This information gap creates significant challenges for institutions and individuals in designing care protocols or developing policies. Lack of consideration of trans people in protocols and policies provides for continued erasure of trans people's needs and does not signal their importance or even existence to staff and providers. This erasure promotes the ongoing failure to recognize areas in which information is lacking and to conduct research to fill these information gaps. The continuing underestimation of the size or strength of trans populations allows for continued assumptions that systems do not need to be adapted to be trans-appropriate and that trans people can be dealt with on an individual basis. These assumptions serve to make a given system inaccessible for potential trans clients and affect the quality of care that can be provided.

Discussion

Cisnormativity

Underlying the processes of erasure is cisnormativity. Cisnormativity describes the expectation that all people are cissexual, that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women. This assumption is so pervasive that it otherwise has not yet been named. Cisnormative assumptions are so prevalent that they are difficult at first to even recognize. Cisnormativity shapes social activity such as child rearing, the policies and practices of individuals and institutions, and the organization of the broader social world through the ways in which people are counted and health care is organized. Cisnormativity disallows the possibility of trans existence or trans visibility. As such, the existence of an actual trans person within systems such as health care is too often unanticipated and produces a social emergency of sorts because both staff and systems are unprepared for this reality.

Serano (2007) has added to the concept of how erasure of trans people is manifest in language. Serano built a strong case for the importance of the use of "cissexual" as a way to describe those who are nontrans or, by extension, as a means to call attention to the privilege and legitimacy given to individuals who are otherwise known simply as "normal" men and women. This language provides a means to understand not just that trans people are erased through social inertia but, instead, this erasure is necessarily produced and sustained through the embodied privilege and assumptions held by many cissexual researchers, clinicians, and policy makers. Cisnormative assumptions and practices have a real effect on trans people's experiences and health.

Navigating Cisnormative Systems

Data from this study showed numerous challenges that trans participants have in navigating cisnormative health care systems. They have difficulty finding health care providers who can provide trans-competent care, both in terms of providing a trans-friendly environment and having specific knowledge of trans health issues. Trans patients have often taken on the burden of attempting to educate the providers they have gone to for specific expertise. Trans patients have had to endure the indignity of being placed in sex-segregated wards or sent to sex-specific service clinics that were not appropriate to their felt or visible gender. Negative experiences, or fears of having

Table 2. Recommendations for Inclusion of Trans People in Informational Contexts

- Identification of trans participants in all research
- Awareness of and attention to cisnormative assumptions in research questions
- Prioritization of research on trans-specific needs
- Assurance that research represents diversity of trans communities and addresses needs of specific segments of the community
- Involvement of trans people in identifying research priorities
- Assurance that research questions and approaches are nonpathologizing and community-sensitive
- Incorporation of trans health issues into textbooks
- Incorporation of trans health concerns into medical, nursing, medical assistant, social work, and psychology curricula
- Provision of training on creating a trans-friendly clinical environment
- Provision of continuing education credits for trans health-related workshops

negative experiences, have caused some people to avoid health care settings or to self-treat. Others have chosen to not disclose their trans status whenever possible. For trans people who have the option of passing as cissexual, the choice often exists as to where and when and to whom to disclose. Yet choice is often an illusion in which all options carry risks. For example, a trans person in need of emergency health care has the "choice" to self-disclose his or her medical history and hormone use. Disclosure involves the risk of denial of care or mistreatment; lack of disclosure involves the risk of inappropriate health care and possible unintentional disclosure through medical examinations or testing. The onus should not be on trans people to make themselves visible in vulnerable situations, to educate persons in positions of greater power, or to try to change policies to accommodate their needs, especially at a time of need or distress.

Recommendations to Counter Erasure

Countering the systematic erasure of trans people in informational and institutional contexts is an important intervention in support of the health and well-being of trans people. Based on data from the community soundings and the understanding of erasure and its cisnormative underpinnings that emerged, recommendations regarding the inclusion of trans people within the health care system are made (see Tables 2 and 3).

Resources are available, including guidelines for trans-specific health care needs. Bockting and Goldberg (2006) provide a collection of guidelines by multiple authors encompassing primary care, counseling, endocrine therapy, surgical care, speech therapy, case advocacy, and clinician training that addresses adolescent as well as adult care. Ettner, Monstrey, and Eyler (2007) published a comprehensive technical resource for health care professionals on medical and surgical care. Other authors have provided information and guidelines for working with trans clients and their families (Ettner, 1999; Lev, 2004). Additional HIV-specific resources are included later.

Implications for HIV Prevention, Treatment, and Care

As a concept, erasure has considerable implications for those working in HIV prevention, treatment, and care, in which cisnormative assumptions have shaped responses to the epidemic. In most Western countries, funding decisions are organized around defined risk groups. For example, as researchers have begun to understand the complexity of gay culture and gay men's sexual behavior, targeted and sophisticated prevention and care programs have been developed. Little is understood, on the other hand, about trans people, their vulnerability to HIV, their sexual relationships and behaviors, how HIV risk is shaped by social determinants of health, and how the dual stigma of trans and HIV impacts disclosure of HIV status and trans identity for transgender persons living with HIV.

Other than programs that specifically target trans participants (Bockting, Rosser, & Coleman, 2001; Hein & Kirk, 2001), HIV prevention interventions typically assume that all bodies are cissexual and that people engage in particular kinds of sexual activities. Moreover, the erasure of trans people in HIV prevention work reflects and reinforces the

Table 3. Recommendations for Inclusion of Trans People in Institutional Contexts

- Development of intake forms that allow for trans patients or clients to self-identify
- Assumption by providers that any patient may be trans
- Assurance that all providers and staff use pronouns and names appropriate for a patient's gender identity, asking the patient if in doubt
- Indication of trans-friendly environments through posters or other visible signals
- Development of protocols for testing or treatment that are not sex-specific or that do not assume all members of a sex are cissexual
- Assurance that there is a comfortable place for trans patients within sex-segregated systems such as hospital wards or elimination of sex segregation where possible
- Development of resources for referral to trans-friendly providers, where needed
- Assurance that billing systems are set up to accommodate scheduling and billing "women's" services to men, and "men's" services to women
- Removal of sex designations from identifying documentation unless necessary

dominant perceptions of what bodies are normal and "real" and can in turn adversely affect self-esteem. Some trans people use black market hormones or share needles for hormone injection, yet they and their providers may know very little about the transmission risks associated with these activities. Moreover, service providers should be cognizant of access barriers to HIV testing that trans people may experience. McWilliam, Leonard, Medd, and members of the Ontario Women and HIV Working Group (2007) and the Center of Excellence for Transgender HIV Prevention (2008) offer recommendations and best practices for HIV prevention in trans communities.

The negative experiences that trans people face in the health care system may cause some to hide their trans identity when accessing HIV services. The dual stigma of being trans and HIV-infected may also result in people choosing not to disclose their trans identity or alternately not wanting to know or disclose their HIV status. Without knowing the full range of issues and concerns that clients bring to care, it is difficult for providers to develop quality care plans. Surgeons who are not familiar with trans health issues may refuse to perform procedures on HIV-infected trans people, although guidelines exist for selecting HIV-infected patients for sex reassignment surgery (Kirk, 2001), and HIV-related medications present another set of issues. It is unlikely that any antiretroviral medications have been tested on trans people, and the potential for adverse reactions and harm is, therefore, not well understood. Moreover, hiding one's trans identity from a care provider may have significant implications for adverse interactions between HIV medications and hormones.

Conclusion

This project was undertaken not merely to describe the challenges that trans people experience because these have been documented in previous needs assessments. Rather, the information was obtained to provide an understanding of the ways in which these challenges are brought into existence. As patterns emerged in the experiences that were shared, it was difficult to understand how social determinants of health, such as access to health care, affect the lives of trans people without understanding the processes through which trans people are actively and passively erased. Using information shared at the community soundings, the etiology and outcomes of erasure were explored: how erasure took shape and the role that it played in the experiences of trans people within health care systems.

This work further developed the concept of erasure within trans communities by identifying specific contexts in which erasure occurred and delineating ways in which this process functions. Specific recommendations have been provided to begin to remedy erasure. Whereas this article has focused on issues in health care, the processes of erasure outlined herein have application to other areas in which trans individuals interface with institutions or systems around issues such as housing, employment, and social services. Although this work sought to expand the theoretical basis for social exclusion of trans people, the theoretical and practical are not discrete areas. One participant phrased it well, as follows:

> [T]he barriers remain within the larger society and even within the larger LGBTTQ [lesbian,

gay, bisexual, trans, two-spirit, and queer] community, acceptance of who we are as equal and deserving of the same resources, the same attention. And what's the word? Erasure—which all of [us] are familiar with as a theoretical and practical term. I don't think this is theoretical; this is our lives.

Clinical Considerations

- Trans people experience barriers to receiving health care including avoidance of health care, refusal of care, difficulties getting referrals, lack of provider information on trans issues, and uncomfortable or problematic interpersonal interactions.
- The processes of erasure in information production and dissemination and in institutional protocols, practices, and policies create a system that produces further social marginalization of trans people. Social marginalization creates inequities in health, such as increasing risk of depression and HIV vulnerability.
- Trans people present as patients in all areas of health care and are often not immediately recognizable as trans people to health care providers. The incorporation of trans-friendly practices and protocols make it easier for patients to seek care, self-identify, and have their health care needs met.
- Nurses are in key positions to affect trans patients' experiences in health care. Moreover, clinical nurses and managers are well-positioned to impact trans-friendly practices within care settings, and nurse researchers can incorporate trans participants and issues into health-related research on a broad range of topics.

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